STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT 89 17

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group "D"

B. Areas of State in which services will be provided:

/X/ Entire State.

/_/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/_/ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's Intensive Case Management Program and who:

(i) are seriously and persistently (chronically) mentally ill and

(ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community and

(iii) either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

(1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;

(2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;

(3) mentally ill who are homeless and live on the streets or in shelters;

(4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized.

The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D

Entire State

D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service with assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.

3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.

4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D"

Case management for Target Group "D" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

A. **Intake and screening.** This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. **Assessment and reassessment.** During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. **Case management plan and coordination.** The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient ; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;

2. the continuity of service;

3. the avoidance of duplication of service (including case management services); and,

4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. **Implementation of the case management plan.** Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. **Monitoring and follow-up.** As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

   An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

   An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS.**

   The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

   The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

   The case management plan must specify:

   a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;

   b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

   c. the type of treatment program or service providers to which the recipient will be referred;

   d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and

   e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

3. **Continuity of service.** Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district*; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving clients in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving instititutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligiblity determinations/redeterminations;

3. Medicaid preadmission screening;

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4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "D"

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients are seen a minimum of four times during a month. Active seriously emotionally disturbed children in the ICM program must receive four contacts during a month, three face-to-face and the fourth face-to-face may be with either the client or a collateral. Collaterals are defined in 14 NYCRR Part 587.4(a)(2) as members of the patient's family or household, or significant others who regularly interact with the patient and are directly affected by or have the capability of affecting the patient's condition and are identified in the treatment plan as having a role in treatment and/or identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the patient prior to admission. Each Office of Mental Health Regional Office shall maintain a listing by name (roster) of individuals meeting the basic participation criteria. These individuals may be referred to the roster by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager will determine which are viable to become active (i.e. that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for return to the roster. Clients returned to rostered status may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. state and local governmental agencies; and

d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "D"

1. Providers

The New York State Department of Social Services will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations determined by OMH and certified to SDSS to have the capacity to provide specialized Intensive Case Management Services.

2. Case Manager

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor's degree in a human services field* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a